MERITAIN HEALTH

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Meritain Health
1405 Xenium Lane North, Suite 140
Minneapolis MN 55441

Forwarding Service Requested

**********ALL FOR AADC 730
PB-KCK-702-ENV 4493 13
DANIELLE BARRON
[redacted]

Customer Service Information

Need help understanding your benefits? Contact Us.

866-596-5817

Division: 004
Draft Ref #:
Participant: DANIELLE BARRON
ID NO: MM671746592
Patient: E[redacted] BARRON
Patient Acct #: [redacted]
Prepared On: 03/26/2019 **By:** CYW
Benefit Year: 2019 **Claim:** Medical
Provider: KAMILAH SHY

Provider TIN: [redacted]

Claim #: 6I13296 **Provider:** KAMILAH SHY
Patient: E[redacted] BARRON **Patient #** [redacted]

Treatment Dates	Procedure / Revenue Code	Billed Amount	Provider Discount	Ineligible Amount	Reason Code	Applied to Deductible	Applied to CoPay	Paid At	Other Payment	Payment Amount	Patient's Responsibility
02/06/19-02/06/19	01210 /	$2,945.00	$0.00	$2,945.00	a	$0.00	$0.00	0%	$0.00	$0.00	$2,945.00
02/06/19-02/06/19	62326 /	$676.00	$0.00	$676.00	a	$0.00	$0.00	0%	$0.00	$0.00	$676.00
Column Totals		**$3,621.00**	**$0.00**	**$3,621.00**		**$0.00**	**$0.00**		**$0.00**	**$0.00**	**$3,621.00**

Patient's Responsibility: $3,621.00

Other Insurance Credits	$0.00
Total Payment Amount	$0.00

Accumulators

Description	Satisfied	Claim Year
Individual Deductible	$320.22 of $5000.00	2019

Reason Code Description

a. Charges ineligible based on the exclusions outlined in your benefit plan.

* Provider discount through AETNA PPO. Patient not responsible for this amount. ORIGINAL.SUBMISSION: 6I97978 This expense is not covered. Please refer to exclusion #59.

* We are accepting claims electronically through ClaimLynx, Claimsnet, or WebMD. Our Payor ID is 41124.

This document contains important information that you should retain for your records.
If your claim was denied (in whole or in part), the decision to deny your claim was based on the Medical Benefits and/or Plan Exclusion section(s) of the Plan because the benefits requested are not covered by the Plan and this document may serve as notice of an adverse benefit determination. (Please refer to the reason(s) provided for additional information.)

If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights). This claim was processed in accordance with your Plan Document.

You Should Know

This notice is NOT a bill. The amount identified as patient responsibility may have already been paid to the provider at the time of service or you may have paid a different amount at that time. Please contact your provider with any billing questions.

The following language is required by law and is for informational purposes only. This language is intended to assist those plan participants who may not speak English as their predominant language.

SPANISH (Español): Para obtener asistencia en español, por favor póngase en contacto con el número de teléfono que aparece arriba.
TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog, mangyaring tumawag sa numero na nasa itaas.
CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjí' nikáʼa'doowołgo, t'áá shǫǫdi hodahdi bèèsh bee hane'é binumber bikáá'ígíí bish'į' hodíilnih.

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**********SCH 5-DIGIT 73003
19022 1 AV 0.383 85
DANIELLE BARRON
[redacted]

Customer Service Information

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866-596-5817

Division: 004
Draft Ref #:
Participant: DANIELLE BARRON
ID NO: MM671746592
Patient: [redacted] BARRON
Patient Acct #: [redacted]
Prepared On: 04/09/2019 **By:** HL2
Benefit Year: 2019 **Claim:** Medical
Provider: THOMAS LEWIS

Provider TIN: [redacted]

Claim #: 6IQ4704 **Provider:** THOMAS LEWIS
Patient: E[redacted] BARRON **Patient #** [redacted]

Treatment Dates	Procedure / Revenue Code	Billed Amount	Provider Discount	Ineligible Amount	Reason Code	Applied to Deductible	Applied to CoPay	Paid At	Other Payment	Payment Amount	Patient's Responsibility
02/06/19-02/06/19	27299 /	$9,074.00	$0.00	$9,074.00	a	$0.00	$0.00	0%	$0.00	$0.00	$9,074.00
02/06/19-02/06/19	27140 /	$3,733.00	$0.00	$3,733.00	a	$0.00	$0.00	0%	$0.00	$0.00	$3,733.00
02/06/19-02/06/19	27054 /	$2,200.00	$0.00	$2,200.00	a	$0.00	$0.00	0%	$0.00	$0.00	$2,200.00
Column Totals		**$15,007.00**	**$0.00**	**$15,007.00**		**$0.00**	**$0.00**		**$0.00**	**$0.00**	**$15,007.00**

Patient's Responsibility: **$15,007.00**

Other Insurance Credits	$0.00
Total Payment Amount	$0.00

Accumulators

Description	Satisfied	Claim Year
Individual Deductible	$894.82 of $5000.00	2019

Reason Code Description

a. Charges ineligible based on the exclusions outlined in your benefit plan.
* Provider discount through AETNA PPO. Patient not responsible for this amount. Charges are excluded under the plan. Please see exclusion #59. ORIGINAL.SUBMISSION: 6IG4037

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CHINESE (中文): 需要中文帮助,请拨打上面的号码与我们联系。
NAVAJO (Dine): Dinék'ehjí' nikáa'doowołgo, t'áá shoodi hódahdi béésh bee hane'é binumber bikáá'ígíí bish'į' hodiilnih.

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at the customer service number located on the front of this notice if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You or your authorized representative or provider acting on behalf of the member has the right to appeal any decision not to provide or pay for an item or service (in whole or in part).

How do I file an appeal? You or your authorized representative or provider has the right to an appeal within 180 days of the date you receive a denial. If you decide to appeal this claim, your appeal (including any additional information you would like to provide) should be sent in writing to Attn: Appeal Department, Meritain Health, P. O. Box 41980, Minneapolis, MN 55441-0970 or to the address outlined in your Certificate. See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 48 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal or you may contact us at the customer service number located on the front of this notice.

Who may file an appeal? You or someone you name to act for you (your authorized representative or provider) may file an appeal. You can appoint an authorized representative by requesting an Appointment of Authorized Representative form at www.meritain.com.

Can I provide additional information about my claim? If your claim was denied and you have been offered the opportunity to provide additional information to have your claim reconsidered (as identified on the front of this notice), you have 50 days from the date of this notice to provide the additional information.

Can I request copies of information relevant to my claim? Yes, upon written request, you may request copies (free of charge) of all relevant documents, information and records and to send us your comments in writing. You may also request (in writing) a copy of any internal rule, guideline or protocol that was relied upon in processing your claim, including an explanation of the scientific or clinical judgment that was applied to any claim that was denied based on a medical necessity, experimental treatment or similar exclusion or limit contained in the Plan. If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at the customer service number located on the front of this notice.

What happens next? If you appeal, we will review our decision and provide you with a written determination, and we will process the appeal in accordance with your Plan document and applicable law.

For more information on how to file a request for an external review with the Plan contact the customer service number located on the front of this EOB. You may also direct questions regarding the status of your health plan to your plan administrator or by contacting us at the customer service number located on the front of this notice

Other resources to help you: A consumer assistance program can help you file your appeal. Contact:
Oklahoma Insurance Department
Five Corporate Plaza
3625 Northwest 56th Street, Suite 100
Oklahoma City, OK 73112-4511
(800) 522-0071 (in-state only)
(405) 521-2828
https://www.ok.gov/oid/Consumers/Consumer_Assistance/ (website)